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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC #1	445491	A. BUILDING 01 - MAIN BUILDING B. WING _____	06/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCKENDREE VILLAGE INC	4347 LEBANON ROAD HERMITAGE, TN 37076

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities on 06/05/2018. During this Life Safety Survey, McKendree Village was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2012. The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 133 SS=D	Multiple Occupancies - Construction Type CFR(s): NFPA 101 Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain separated occupancies.	K 133	**K133 Multiple Occupancies – Construction Type NFPA 101** The facility has and will continue to maintain appropriate fire rated doors. On or before July 20, 2018, the Health Care Maintenance staff will attend an in-service. The In-service will be conducted by the Director of Facilities Management or designee and will include: • Review of the regulation • Review of the statement of deficiency • Review of the plan of correction • Standards for maintaining Cross Corridor fire rated doors The facility 1 ½ hour rated fire doors located at the Assisted Living/ Nursing	July 20, 2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Suzanne Hogan LNHA | Administrator | 6-26-2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

received 6-26-18

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K 133	Continued From page 1 The findings included: Observation on 06/07/2018 at 11:58 AM, revealed the 1 1/2 hour fire rated doors of the Assisted Living/Nursing Home occupancy separation wall by the gift shop did not have bottom latching hardware. NFPA 101, 19.1.3.5 (2012 Edition) NFPA 101, 19.1.3.3* (2012 Edition) NFPA 101, 8.3.3.1 (2012 Edition) NFPA 80, 4.6.3.1* (2010 Edition) Observation on 06/07/2018 at 12:06 PM, revealed the 1 1/2 hour fire rated doors of the Assisted Living/Nursing Home occupancy separation wall by the Link at the South Building did not have bottom latching hardware. NFPA 101, 19.1.3.5 (2012 Edition) NFPA 101, 19.1.3.3* (2012 Edition) NFPA 101, 8.3.3.1 (2012 Edition) NFPA 80, 4.6.3.1* (2010 Edition) Maintenance staff was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 06/05/2018.	K 133	Home separation wall by the Gift Shop and the doors by the Link at the South Building will have thermal fire pins added to the lower portion of the doors as specified by the Sargent 80 series hardware model 12-NB8700 installation instructions. No other issues with door latching mechanism on cross corridor fire rated doors were identified. Beginning July 6, 2018, the Maintenance Supervisor or designee will monitor the hardware on cross corridor fire rated doors during Facilities Management's monthly fire drills. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or Supervisor. The Facilities Management Director will report any trends or patterns to the QAPI Committee who will determine the frequency of further monitoring.	July 20, 2018
K 311 SS=D	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire	K 311	**K311 Vertical Openings – Enclosure NFPA 101** The facility has and will continue to maintain appropriate stairwell fire rated doors. On or before July 20, 2018, the Health Care Maintenance staff will attend an in-service. The in-service will be conducted by the Director of Facilities Management or designee and will include: • Review of the regulation • Review of the statement of deficiency • Review of the plan of correction	July 20, 2018

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K 311	Continued From page 2 resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to maintain the vertical openings. The findings included: Observation on 06/05/2018 at 2:14, PM, revealed the the door to the stairwell by the medical records room on the second floor did not latch within the frame. Maintenance staff was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 06/05/2018.	K 311	• Standards for maintaining fire rated doors The stairwell door's hardware that would not latch located by the Medical Records department on the second floor will be replaced with the proper latching hardware. Other issues with door latching mechanism on stair well doors were remedied. Beginning July 6, 2018, the Maintenance Supervisor or designee will monitor stairwell fire rated doors during Facilities Management's monthly fire drills. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or Supervisor. The Facilities Management Director will report any trends or patterns to the QAPI Committee who will determine the frequency of further monitoring.	July 20, 2018

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K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96	K 324	**K324 Cooking Facilities NFPA LIFE SAFETY CODE 101** The facility has and will continue to maintain appropriate training programs for dietary staff members on fire safety. On or before July 20, 2018, the Dietary Staff will attend an in-service. The in-service will be conducted by the Director of Facilities Management or designee and will include: • Review of the regulation • Review of the statement of deficiency • Review of the plan of correction • Procedures for responding to a fire in the Dietary department.	July 20, 2018

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K 324	Continued From page 3 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to protect the cooking facilities. The findings included: Observation on 06/05/2018 at 12:36 PM, revealed kitchen staff member #1 did not know the know the proper fire control procedures including the activation of the hood suppression system as the primary means of fire suppression and the use of a fire extinguisher as a secondary means. NFPA 101, 19.3.2.5.1 (2012 Edition) NFPA 96, 10.2.1 (2011 Edition) Maintenance staff was present when these deficiencies were identified and the administrator acknowledged these deficiencies during the exit conference on 06/05/2018.	K 324	The Facilities Management Director or a designee will assure the training procedures for the Dietary Department include the activation of the hood suppression system as the primary means of fire suppression and the use of a K fire extinguisher as a secondary means of fire suppression. On or before July 6, 2018, the Facilities Management Director or Supervisor will perform a drill in the Dietary Department to monitor staff response and ensure staff's knowledge of the proper procedures. Also, the Maintenance Supervisor or designee will interview random Dietary Staff regarding the procedure for responding to a fire in the Dietary Department during Facilities Management's quarterly fire drills to assure they are responding appropriately. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or Supervisor. The Facilities Maintenance Director will report any trends or patterns to the QAPI committee who will determine the frequency of further monitoring.	July 20, 2018

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K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design,	K 353	**K 353 Sprinkler System – Maintenance and Testing NFPA LIFE SAFETY 101** The facility has and will continue to maintain appropriate sprinkler systems. On or before July 20, 2018, the Health Care Maintenance staff will attend an in- service. The in-service will be conducted by the	July 20, 2018

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K 353	Continued From page 4 maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, the facility faield to maintian the sprinkler system. The findings included: Observation on 06/05/2018 at 12:27 PM, revealed the 2 sprinkler escutcheon plates missing in the Admissions Assistant office. NFPA 101, 19.3.5.1 (2012 Edition) NFPA 101, 9.7.5 (2012 Edition) NFPA 25, 5.2.1.1.4 (2011 Edition) Maintenance staff was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 06/05/2018.	K 353	Director of Facilities Management or designee and will include: • Review of the regulation • Review of the statement of deficiency • Review of the plan of correction • Standards for maintaining sprinkler heads and escutcheon plates. The two missing sprinkler escutcheon plates in the Admissions Assistant Office were be replaced on 6/5/18. No other missing escutcheon plates were found. Beginning July 6, 2018, the Maintenance Supervisor or designee will monitor sprinkler heads and escutcheon plates during Facilities Management's monthly preventive maintenance rounds. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or Supervisor. The Facilities Management Director will report any trends or patterns to the QAPI committee who will determine the frequency of further monitoring.	July 20, 2018
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing	K 511	**K511 Utilities – Gas and Electric NFPA LIFE SAFETY CODE 101** The facility has and will continue to make sure no extension cords are used in the facility.	July 20, 2018

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K 511	Continued From page 5 installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to maintian the utilities. The findings included: Observation on 06/05/2018 at 12:29 PM, revealed an extension cord in use to power a power-strip in the Admission directors office. NFPA 101, 19.5.1.1 (2012 Edition) NFPA 101, 9.1.2 (2012 Edition NFPA 70, 590.3 (2011 Edition) Maintenance staff was present when these deficiencies were identified and the Administrator acknowledged these deficiencies during the exit conference on 06/05/2018.	K 511	On or before July 20, 2018, the Health Care Maintenance staff will attend an in-service. The In-service will be conducted by the Director of Facilities Management or designee and will include: • Review of the regulation • Review of the statement of deficiency • Review of the plan of correction • Prohibition of extension cord use in the facility No other extension cords were found in any room or office in the facility. Beginning July 6, 2018, the Maintenance Supervisor or designee will monitor for extension cords monthly during Facilities Management's preventive maintenance rounds. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or Supervisor. The Facilities Management Director will report any trends or patterns to the QAPI committee who will determine the frequency of further monitoring.	July 20, 2018

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E 000	Initial Comments A Emergency Preparedness Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities survey on 06/05/2018. During this Emergency Preparedness Survey, McKendree Village was not found in substantial compliance with the requirements for participation in Emergency Preparedness Regulations for Long-Term Care Facilities, Federal CFR §483.73. The requirement at 42 CFR, §483.73 are NOT MET as evidenced by:	E 000		
E 039 SS=D	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a	E 039	**E 039 EP Testing Requirements** The facility has and will continue to exercise the appropriate Emergency Preparedness Drills. McKendree Village has joined and is actively attending Highland Rim Healthcare Coalition Meetings, whose purpose is to prepare, respond, and recover from short or long term incidents that have a public health and medical impact within Tennessee Emergency Medical Services Region 5. Representatives from the McKendree Village Management Team will participate in the next full-scale community-based drill when available. Once the exercise is over, the Emergency Control Group will evaluate strengths and	July 20, 2018

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Suzanne Hogan LNHA | Administrator | 6-26-2018

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E 039	Continued From page 1 community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed conduct exercises to test the	E 039	weaknesses of the facility's response during the exercise and may adjust the emergency response plan accordingly. Documentation will be kept on file in the Facilities Management Department and will be reviewed by the Executive Director, Health Center Administrator, and the Facilities Management Director. The Facilities Management Director will report any trends or patterns to the Safety Committee and the QAPI committee who will determine the frequency of further monitoring and next steps.	July 20, 2018

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E 039	Continued From page 2 emergency plan at least annually per the requirements of Federal CFR §483.73(d)(i) and CFR §483.73(d)(ii) . The findings include: Document review and interview with the Administrator and Executive Director on 06/05/2018 at 02:45 PM confirmed the facility failed to participate in a full-scale exercise that is community-based. The Administrator and Executive Director were present when this deficiency was identified and the Administrator acknowledged these deficiencies during the exit conference on 06/05/2018.	E 039		

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{K 000}	INITIAL COMMENTS A Life Safety revisit survey was conducted on 07/24/2018 for all previous deficiencies cited on 06/05/2018. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCKENDREE VILLAGE INC	4347 LEBANON ROAD HERMITAGE, TN 37076

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments An Emergency Prepardness revisit survey was conducted on 07/27/2018 for all previous deficiencies cited on 06/05/18. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed.	{E 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.